**How to complete CRFs**

**How do I find out the unique LASOS identifier code for my patient?**

A unique code is created for each patient but not until you enter the data onto the internet based electronic case record form (eCRF).

**Why and How do I record the ethnicity in CRF?**

From a LASOS point of view, recording ethnicity is absolutely necessary because researchers are identifying inequalities in patient outcomes between ethnic groups, and the issue has been recognized as very important at an international level. We understand that we have many options in Latin America, but we choose common original ethnicity terms that we will see in all countries. We want to use the ethnic group patients personally identify with. Some hospitals include this information on patient registers, but others do not. We understand the limitations of this item, and we encourage you to ask patients about their ethnicity, if possible. The option “other” can be used to describe all terms that were not contemplated. The investigators can leave the question as ‘unknown’ where the data are unavailable or not possible to collect.

Ethnicity will be recorded according to the following:

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|  | **English** | **Spanish** | **Português** |
| 1 | Afro-descendent | Afro-descendiente | Afro-descendente |
| 2 | white | blanco | branca |
| 3 | indigenous | indígena | indígena |
| 4 | other | otro | outra |
| 5 | unknown | desconocido | desconhecida |

**How should we decide the American Society of Anaesthesiologists ASA score?**

The definition of ASA score is of utmost importance. We strongly recommend that all investigators review the last update Approved by the ASA House of Delegates on October 15, 2014, and last amended on December 13, 2020). All anesthesiologists involved in assistance should be encouraged to the correct use during the data collection period.

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|  | **Definition** | **Examples** |
| **I** | normal healthy patient | Healthy, nonsmoking, no or minimal alcohol use |
| **II** | patient with mild systemic disease which does not limit physical activity | Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI  <40), well controlled DM/HTN. Mild lung disease. |
| **III** | patient with severe systemic disease which limits physical activity | Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents. |
| **IV** | patient with severe systemic disease that is a constant threat to life | Recent (<3 months) MI, CVS, TIA or CAD/Stents, ingoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis. |
| **V** | patient who is not expected to survive for 24 hours without the operation | Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction |

**What are the definitions for the chronic co-morbid disease?**

We have not made any definitions for these diseases. We realize that many doctors will not have time to read an extensive definition manual. We simply want doctors to give what they believe is the most appropriate answer. If the patient probably has the disease, then tick the box if they probably do not then leave it blank.

**What shall I do if my patient has important medical problems which aren’t listed in the chronic co-morbid disease section of the Operating Room CRF?**

We realize that some patients may have important data which we do not ask for. The CRF has been designed to request only the most important patient data.

**Some patients will not have any blood tests requested (eg creatinine). Should we take blood samples so we can run these tests just for the study?**

No. We do not want you to make any changes to the diagnostic tests or clinical treatment your patients would normally receive. If blood results are not available, please leave this domain empty.

**What if the data requested is not available?**

It is likely that some data such as blood results will not always be available. You should not order additional tests unless they are required for clinical reasons.

**How is anaesthetic technique defined?**

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| **General anaesthesia**: Pharmacologically induced state of unconsciousness in order to facilitate surgical procedure. |
| **Sedation:** Pharmacologically induced reduced level of consciousness during which verbal contact is maintained. |
| **Spinal anaesthesia:** injection or infusion of a clinically effective dose of local anaesthetic and / or opioid drugs into the cerbro-spinal fluid in order to provide clinically effective anaesthesia. |
| **Epidural anaesthesia**: injection or infusion of a clinically effective dose of local anaesthetic and / or opioid drugs into the epidural space in order to provide clinically effective anaesthesia. |
| **Local anaesthesia**: injection of a clinically effective dose of local anaesthetic into the tissues at the site of surgery in order to provide clinically effective anaesthesia |

**What do you mean by severity of surgery?**

This is the category of surgery which indicates a combination of complexity and amount of tissue injury.

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| **Minor surgery** would include procedures lasting less than 30 minutes performed in a dedicated operating room which would often involve extremities or body surface or brief diagnostic and therapeutic procedures eg arthroscopy without intervention, removal of small cutaneous tumour, diagnostic proctology, biopsy of small lesions, etc. |
| **Intermediate procedures** are more prolonged or complex that may pose the risk of significant complications or tissue injury. Examples include laparoscopic cholecystectomy, arthroscopy with intervention, bilateral varicose vein removal, tonsillectomy, inguinal hernia repair, breast lump resection, haemorrhoidectomy, appendicectomy, partial thyroidectomy, cataract surgery, uvuloplasty, minimally invasive repair of vaginal prolapse, vaginal hysterectomy, tendon repair of hand, fixation of mandibular fracture, etc. |
| **Major surgical procedures** are expected to last more than 90 minutes and include major gut resection, major joint replacement, mastectomy, extensive head and neck tumour resection, abdominal aortic aneurysm repair, major vascular bypass procedure, procedures involving free flap to repair tissue defect, amputation, total thyroidectomy, cystectomy, trans-urethral resection of prostate, resection of liver tumour, carotid endarterectomy, nephrectomy, total abdominal hysterectomy, spinal discectomy, etc. |

**How the duration of hospital stay is defined in LASOS study?**

Duration of hospital stay is defined as time in days from the day of surgery to the day the patient leaves your hospital. This will not be adjusted for delays relating to provision of social care.

**What about patients who are still in hospital many months after surgery?**

This will happen for a small number of patients. Because we need complete data entry quickly, we have decided to censor follow-up at thirty days. So all patients are followed until hospital discharge or for thirty days after surgery whichever is the shortest. If a patient remains in hospital after 30 days, please tick ‘alive’ to status at 30 days after surgery If the patient was discharged alive before day 30 please tick ‘alive’ and record number of days in hospital after the surgery. Day of surgery is a day zero, for instance if patient has had a surgery on Monday and was discharge on Wednesday, the total number of hospital stay after surgery is two.

**How is elective surgery defined in LASOS?**

Elective surgery is not immediately life-saving and is usually planned over a period of weeks or months before the procedure.

**How is critical care defined in the LASOS study?**

We have defined a critical care unit as a facility routinely capable of admitting patients who require invasive ventilation overnight. Definitions vary from country to country but we must use one standard for all patients included in the ISOS study. This is different to the definition of a post-anaesthetic recovery unit which has the primary purpose of providing care for all patients after anaesthesia regardless of organ support.

**How do I record the duration of stay in Post-Anaesthetic Care Unit on the Case Report Form if patient was there only e.g. 10 minutes?**

The length of Post-Anaesthetic Care Unit stay should be rounded up to nearest whole hour.

**How do I define and graduate the postoperative complications?**

You can access the document Lasos Complication Definitions. There you will find how the complications are defined and how their severity is categorized.